

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-050551
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 381 Primary Registration District No. 6127 Registrar's No. 110

VS 300
Rev. 4/59

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2/050

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED DEC 31 1963

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Sullivan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Sullivan | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Buchanan Twp. | | Length of stay in 1b Life | c. CITY OR TOWN Green Castle Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Farm home | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Rural Route Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Albert James Allen | | | 4. DATE OF DEATH Month Dec. Day 24 , Year 1963 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 3/5/1884 |
| 9. AGE (last birthday) 79 | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY General farming | |
| 11. BIRTHPLACE (City and state or country) Sullivan Co., Mo. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Benjamin Allen | | 13b. MOTHER'S MAIDEN NAME Margaret Overstreet | |
| 14. NAME OF HUSBAND OR WIFE Golva Allen | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No | |
| 16. SOCIAL SECURITY NO. 07 | | 17. INFORMANT Address Mrs. Golva Allen, Green Castle, Mo. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from <u>12/23/63</u> to <u>12/24/63</u> and last saw him alive on <u>12/23/63</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>J.R. M. Carter M.D.</u> | | 22b. ADDRESS <u>Browning Mo</u> | |
| 22c. DATE SIGNED 12/25/63 | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | |
| 23b. DATE 12/27/1963 | | 23c. NAME OF CEMETERY OR CREMATORY Green Castle Cemetery | |
| 23d. LOCATION (City, town, or county) Green Castle, Mo. | | 24. FUNERAL DIRECTOR ADDRESS <u>Glen E. Kent & Son, Green City, Mo.</u> | |
| 25. DATE RECD. BY LOCAL REG. 12-28-63 | | 26. REGISTRAR'S SIGNATURE <u>Mrs. M.W. Beechett</u> | |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Karl R. Zent

Licensed Embalmer No. 4689

P. O. Address Green City, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.